A personal note, from Gordon D. Reed, M.D.

To My Colleagues in Health Care,

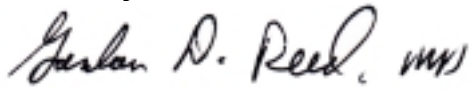
For me, and I suppose for each provider, the question arises "Why?" Why ask about domestic violence (DV)? Why add to my already overwhelming demands? Why not let someone else do it?

The reasons I chose to get involved in this issue are many. It has nothing to do with a personal experience with DV in my own family. It is not something I was forced to do. It was something I read about, started asking patients about, and realized it was something so important that I could not ignore it. It was a place where I could make a difference. It felt *right*. It felt good inside to do something so simple, and that has such a positive impact on someone's life. I felt guilty about the many patients that I failed to ask about DV, and who may have suffered subsequently.

Remembering the things in life that have really stirred my passion about medicine, I think back to my first day of medical school, in August 1982. Dean Bryan Williams was the first speaker, and reflected on his years in medicine. He closed with a saying that I have never forgotten, though sometimes ignored. He said, "We rarely can cure, we usually can comfort, but we always can CARE." There are many other reasons that I choose to ask about DV, but they all pale next to caring.

This manual is intended as an educational tool, and as a handy resource for screening tips and phone numbers. It contains several examples of documentation and assessment tools for various practice settings. The information takes into account relevant Delaware law, and includes the appropriate local and state referral numbers. It is really intended to be an all-inclusive resource, applicable to *your* practice, and one that reduces the frustration of introducing a new concept. I urge each of you to read this manual, learn about DV and ask routinely about it in your practice. I hope it brings each of you the same satisfaction I have enjoyed, touching the lives of our patients with support, understanding, and caring.

Sincerely,



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STATE OF DELAWARE
DOMESTIC VIOLENCE RESOURCE MANUAL
for HEALTH CARE PROVIDERS

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24-Hour DV Hotlines

New Castle County:

Child, Inc.	302-762-6110
Bilingual DV Hotline	1-888-522-2571

Kent and Sussex Counties

Families in Transition	302-422-8058
Bilingual DV Hotline	
8-5 M-F	302-228-5906
Evenings, Weekends and Holidays	302-228-5904

For additional copies or more information, please call the Domestic Violence Coordinating Council (DVCC) at 302-577-2684.

May 2000

SECTION I: OVERVIEW

A. INTRODUCTION

Domestic Violence (DV) is now recognized as a serious social problem that affects the health and well-being of millions of people each year. Though the true scope of domestic violence is nearly impossible to measure, various statistics can help define the issue. For example, the National Domestic Violence Hotline received over 100,000 calls for assistance in 1998. According to a 1998 Commonwealth Fund survey, nearly one-third of American women (31 %) report being abused by a husband or boyfriend at some time in their lives. Moreover, a recent Department of Justice study found that approximately 17% of an estimated 1.7 million people treated in hospital emergency departments for violence-related injuries were injured by a former or current spouse, boyfriend or girlfriend (Rand, 1997).

Over the last 20 years, efforts have been made to improve the response of criminal justice personnel to cases of domestic violence. More recently, health care providers have begun to recognize their crucial role in assisting victims of domestic violence who seek medical treatment. It is clear that victims of domestic violence seek medical care for injuries related to or caused by abuse and there is evidence that screening can increase the number of victims identified and treated in healthcare facilities (Family Violence Prevention Fund, 1999).

The purpose of this Resource Manual is to provide accessible information to healthcare providers in Delaware regarding the screening and treatment of patients who have experienced domestic violence. Because effective screening and treatment can only occur if the Health Care Provider (HCP) has a thorough understanding of the complex dynamics of domestic violence, this manual also provides crucial information regarding victim safety, power and control tactics and community resources.

This Resource Manual was developed by the Medical Subcommittee of the Domestic Violence Coordinating Council of Delaware. The committee membership includes health care providers, domestic violence advocates and affiliated professionals.

B. LEGAL MANDATE

Many clinicians are already screening for DV. Since 1992, the Joint Commission for Accreditation of Health Care Organizations (JCAHO) has required all hospitals to have a policy for screening for DV. This includes admissions to the hospital, as well as outpatient visits to the Emergency Department and Labor & Delivery. The American Medical Association and the American Osteopathic Association, and several specialty societies (including the American College of Emergency Physicians, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American Academy of Nurse Practitioners) all support routine screening of all patients.

C. OVERVIEW of RESOURCE MANUAL

This Resource Manual is organized to provide both in-depth information about domestic violence for the health care professional and information in an abbreviated format for use in our daily work. For example, we have included a *Quick Reference Summary* (Appendix A) that can be read in just two or three minutes. It provides the nuts and bolts needed to care for patients who are victims of DV.

For a more thorough discussion of how a HCP should approach a patient, Section IV, *Health Care Provider's Response* is suggested. It explores the many barriers to addressing domestic violence in the health care setting, explains why patients do not openly disclose abuse and walks the HCP through screening, support, documentation and referral of DV patients.

Section II, *Understanding Domestic Violence*, provides important information on a variety of topics including the dynamics of abusive relationships and safety issues. Section III provides a brief overview of Delaware law regarding DV, and Section V takes a look at both primary and secondary prevention efforts.

Perhaps the most time saving aspect of this manual is the collection of resources and handouts found in the various appendices. Appendix B: Resources on Domestic Violence lists services in our state divided by type and county of referral. The Appendix C: Screening and Assessment Tools contains prompts for history and physical findings, consent for photography, and referral options all on one page. Other appendices offer information on safety planning, child abuse, and elder abuse and provide examples on how to ask about DV. Appendix G includes guidelines for various clinical settings that

offer the provider a quick answer to the question "What should I do if someone tells me they are being abused, or if I'm suspicious?" All of these can be photocopied for your use, or personalized to suit your preferences.

D. ENHANCING the SCREENING and SUPPORT for DV

In addition to enhancing our awareness of DV, several things have been shown to increase the probability our patients will disclose their abuse. First of all, we have to ask about it. Only 15% of clinicians ask about DV, although at least two thirds of battered women say they would have disclosed their abuse if they had been asked by their clinician (Rodriguez et al., 1999). The clinician and the office staff are much more likely to include DV in their routine if it is included on the list of routine questions. If we depend on our memory to ask about DV, it does not become part of our routine. The forms in the appendix can be helpful in this regard. And finally, several studies have shown that an abused person is more likely to disclose their abuse when asked in a safe environment by a compassionate, nonjudgmental clinician. Steps should be taken to ensure the patient's confidentiality and safety when we ask about these delicate issues.

E. GETTING COMFORTABLE with the ISSUE

Although many HCPs will find screening for DV both natural and rewarding, some will likely find it uncomfortable at first. Change is difficult. At the start of the HIV epidemic, many health care providers found it difficult to ask about sexual preferences and practices. It seemed so personal, so invasive to ask our patients about such things. But it is also relevant and important that we ask about these issues. The same is true for DV. Screening for DV will soon become so routine that our patients will expect us to ask about it, just as they expect us to ask about smoking and drinking. Our patients will know that this behavior is not acceptable to us and to society. They will know that, in many instances, abusive behavior is also illegal behavior. They will know that they deserve to have relationships free of violence or the threat of violence. And patients will come to you when they need help, because they know they will find support and appropriate treatment for their problem.

We, the members of the Domestic Violence Coordinating Council Medical Subcommittee, hope this manual will make screening both simple and effective, for the sake of our patients and our future.

SECTION II. Understanding Domestic Violence: The Dynamics of an Abusive Relationship

A. Domestic Violence: Why Does It Happen?

B. Characteristics of Victims and Perpetrators

C. Power and Control Tactics

D. Cycle of Violence

E. Why Victims Stay In Abusive Relationships

F. Effects on Children

G. Safety Planning

A. DOMESTIC VIOLENCE: WHY DOES IT HAPPEN?

Domestic violence is a pattern of abusive and controlling behavior that occurs within an adult intimate relationship. Many factors contribute to the problem of domestic violence. Historically, violence in the family was considered a private matter, best resolved by the family itself. In addition, common law upheld a husband's right to physically punish his wife though this right was not reciprocal (Dobash and Dobash, 1979). These circumstances reinforced the belief that family matters were outside the realm of public scrutiny, leaving victims of domestic violence virtually no recourse but to live with the abuse. Over the last twenty years there have been major shifts in these attitudes and new laws enacted to protect victims of domestic violence. Still the legacy of the past can affect current interventions. For example, health care providers may be reluctant to ask questions considered too personal regarding patients' intimate relationships. Criminal justice personnel may resent the time spent on calls that are "just domestics." These attitudes continue to impede effective intervention efforts and can put victims and their children at increased risk for further abuse.

There is also plenty of evidence to suggest that domestic violence is learned behavior. Research has found that, at least for some perpetrators, exposure to violence in the family as a child may contribute to violent behavior in adult intimate relationships (Hotaling and Sugarman, 1986; Dutton, 1988). In addition, media portrayals of intimate relationships are often violent and highly sexualized and conflicts between partners are characterized by verbal abuse and physical aggression. Of course, the level of generalized violence in the media including movies, television shows and video games contributes to a culture that accepts violence as a means of expression.

Social and religious institutions may also reinforce belief systems that condone a man's right to act as "head of the family." This hierarchical view of family relationships affirms the primacy of the husband/father. Batterers may use this belief to justify the use of violence as a means of controlling an intimate partner. These same institutions may view marriage as an unbreakable bond. Thus, cultural and religious values can reinforce the shame and isolation that so often characterize abusive relationships and create barriers for victims who might otherwise seek help.

Domestic violence is a social problem that can not be defined or explained by any one cause or factor. Violent and abusive behavior in relationships results from a complex mix of learned behavior, cultural values and historical precedent. It is important to note that domestic violence is not caused by the victims' behavior, the use of alcohol or drugs,

stress or mental illness. Domestic violence is learned behavior and can be controlled. Perpetrators make a choice to engage in abusive behavior because they can and because it works.

B. CHARACTERISTICS OF VICTIMS AND PERPETRATORS

Who Are the Victims?

Victims of domestic violence can belong to any socio-economic, ethnic or racial group. They may be old or young, female or male, gay or straight. In heterosexual relationships, the majority of known victims are female.[1] In many cases, the victim's goal in seeking assistance is not to end the relationship but to end the violence. The abuse may affect their ability to get or keep a job, maintain contact with friends and family, and develop connections within their communities. Ultimately, it can have long-term effects on their physical and emotional well-being. Victims are likely to have developed strategies to cope with the violence in their lives and to keep their children safe. Teens in abusive dating relationships are likely to see possessiveness and jealousy as signs of affection. They may be confused by conflicting feelings of love, anger and fear but reluctant to turn to adults for help.

Who Are the Perpetrators?

Perpetrators can also belong to any socio-economic, ethnic or racial group. They too may be old or young, female or male, gay or straight. In heterosexual relationships, the majority of known perpetrators are male. They may have been abused as children or witnessed a parent or other family member being abused. Abusive partners often exhibit a pattern of jealous and controlling behavior that isolates, threatens and frightens their partner. They may see their partner as central to their existence. They may be violent only within the relationship or the family. Violent partners can also be loving partners and caring parents.

[1] *The majority of cases involving heterosexual, intimate violence that come to the attention of the police, courts, shelters and other direct service providers involve women victims and male perpetrators. For example, in 1998 Protection from Abuse orders were issued to 1736 female petitioners and 224 male petitioners by Delaware's Family Court. There is some evidence, based on general population surveys, that male rates of victimization are equal to those of female rates. However, these studies continue to be the subject of much debate regarding the context in which abusive behavior occurs, the use of self defense, and the level of injury resulting from the violence. The fact remains that women are much more likely to be seriously injured or killed as a result of domestic violence. Still, all acts of violence and abuse must be taken seriously and all those at risk screened in health care settings. With the exception of shelter bed space, domestic violence programs in Delaware offer services to male and female victims.

Understanding domestic violence involves accepting that there are no quick fixes or easy solutions. Abusive relationships are first and foremost, relationships. Victims and perpetrators are likely to inhabit the same house, share in the care of children, and have the same circle of friends. As discussed in the section "Why Victims Stay," there are many factors that help to determine whether the couple stays together and whether the abusive or controlling behavior can be changed or stopped.

C. POWER AND CONTROL TECHNIQUES

Physical violence is the most typical form of abuse associated with domestic violence. Yet, victims suffer many types of abuse at the hands of their partners. Sexual coercion and assault are frequently part of the dynamic of a violent relationship. In addition, the power and control tactics described below reflect the common experiences of many victims of relationship violence. These tactics are used by perpetrators of domestic violence to maintain power and control over their partners *(See Figure 1)*.

Economic Abuse

The perpetrator maintains tight control over the couple's finances and oversees what money the victim may have or spend. The perpetrator may not allow the victim to work; may sabotage any efforts the victim makes to get or keep a job and may require that the vicitim relinquish all earnings to the abusive partner.

Coercion And Threats

The perpetrator may threaten to harm the victim, victim's children or other family members. They may also force the victim to engage in acts against her/his will or threaten to turn the victim into the Immigration and Naturalization Service, the Internal Revenue Service or some other government agency. Threats of suicide by the perpetrator are also very common.

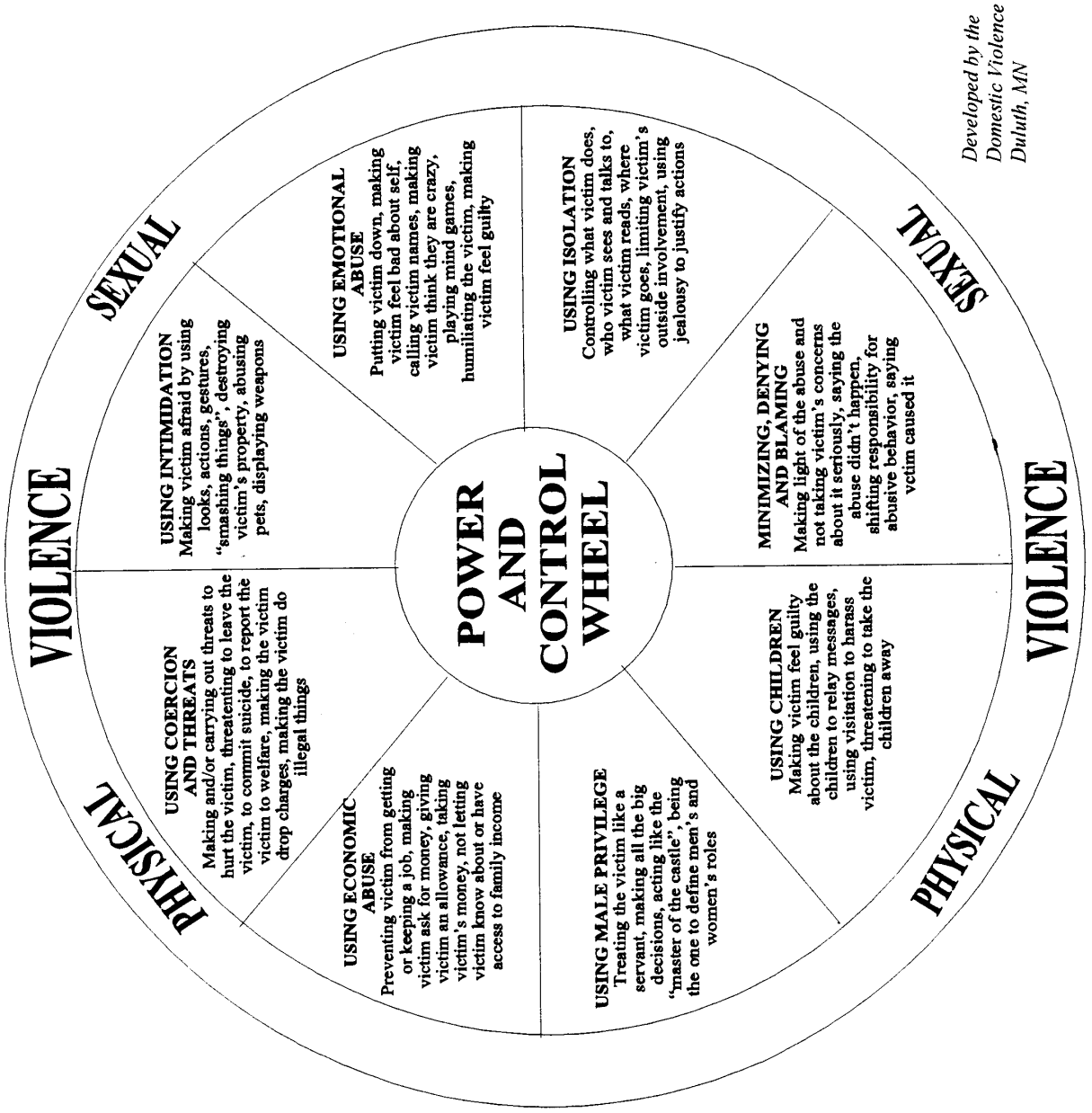
Intimidation

The perpetrator may try to intimidate the victim. This intimidation may occur through menacing looks or expressions, destroying property in front of the victim or by hurting or killing the family pets. Also, the perpetrator may display weapons in front of the victim as a means of frightening her or him.

Emotional Abuse

The perpetrator may use emotional abuse to convince the victim that they are

crazy or irrational, thus causing them to doubt their own beliefs, experiences or feelings. This emotional abuse, in the form of name calling, constant criticism and



Developed by the
Domestic Violence Intervention Project
Duluth, MN

Figure 1

insults, is much more serious than the occasional argument. To the contrary, the perpetrator often continually humiliates and degrades her/his partner, thus wearing away at the victim's self-esteem.

Isolation

The perpetrator often tries to isolate the victim from friends and family members. The victim may not be allowed to leave home without permission and may be forbidden from making telephone calls. Eventually, the victim can become completely cut off from anyone who might be able to help her/him escape from the abuse.

Minimizing, Denying, Blaming

The perpetrator is likely to minimize or even deny their actions even in cases where injury occurs. If the police were called, but did not make an arrest, the perpetrator may rely on their inaction to deny wrongdoing. Also, the abusive partner will often blame the victim for their violent behavior and all too often, the victim will accept at least some responsibility for the abuse perpetrated upon them.

Using Children

Perpetrators may use the children to maintain control over the victim of the abuse. The perpetrator may threaten to harm the children or to kidnap them and flee the jurisdiction. Also, the perpetrator may tell the victim that if they leave, they will have abandoned the children and will lose custody forever. The victim can also be made to feel guilty for breaking up the family if she/he leaves the situation.

Using Male Privilege

Perpetrators may treat the victim like a servant, making all the important decisions, acting like the "master of the castle," being the one to define men's and women's roles.

The majority of domestic violence victims experience some combination of the power and control tactics described above.

D. CYCLE OF VIOLENCE

The Cycle of Violence was first described by Lenore Walker in her 1979 work, The Battered Woman. This model can be useful when trying to understand the complex dynamics that occur in violent or abusive

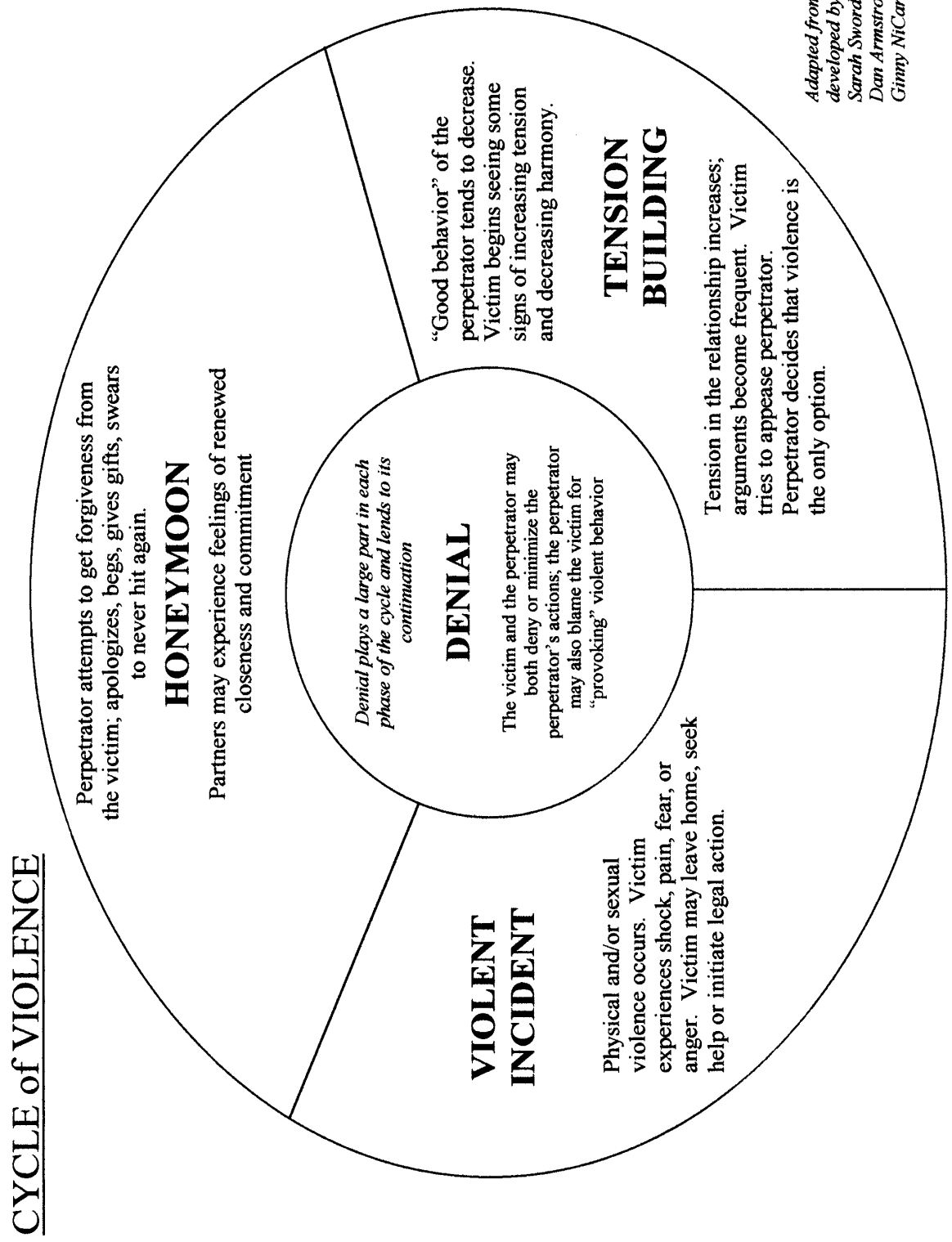

CYCLE of VIOLENCE
Perpetrator attempts to get forgiveness from the victim; apologizes, begs, gives gifts, swears to never hit again.
HONEYMOON
Partners may experience feelings of renewed closeness and commitment
"Good behavior" of the perpetrator tends to decrease. Victim begins seeing some signs of increasing tension and decreasing harmony.
TENSION BUILDING
Tension in the relationship increases; arguments become frequent. Victim tries to appease perpetrator. Perpetrator decides that violence is the only option.
VIOLENT INCIDENT
Physical and/or sexual violence occurs. Victim experiences shock, pain, fear, or anger. Victim may leave home, seek help or initiate legal action.
Denial plays a large part in each phase of the cycle and lends to its continuation
DENIAL
The victim and the perpetrator may both deny or minimize the perpetrator's actions; the perpetrator may also blame the victim for "provoking" violent behavior
Adapted from cycles developed by:
Sarah Swords, MSW
Dan Armstrong, MEd
Ginny NiCarthy

Figure 2

relationships. The Cycle of Violence has been described as having three stages: the tension building stage; the violent episode; and the honeymoon stage. Each stage is defined by certain characteristics. During the tension building phase, the relationship is typified by increasing hostility and stress that may be accompanied by frequent arguments and perhaps limited violence. This stage may eventually escalate to a more serious incident of violent and/or abusive behavior. It is during this second phase, that injury is most likely to occur. It is also at this time that the victim in an abusive relationship may seek some type of intervention or assistance. The violent episode is frequently followed by a third phase, often referred to as the honeymoon phase. This phase is characterized by remorse on the part of the perpetrator and hope for change on the part of the victim (See Figure 2).

Although not all abusive relationships follow this cyclical pattern, the cycle of violence can help to explain what both the victim and the abusive partner are experiencing in many instances. The victim of abuse may be more interested in stopping the violence than in ending the relationship, while the perpetrator may be afraid his/her partner will want to leave. The honeymoon phase represents their efforts to repair and normalize the relationship and may provide the victim with hope that the batterer's behavior will change. In addition, the difficulties involved in ending a violent relationship may seem overwhelming for the victim of domestic violence. Unfortunately, in many abusive relationships the violence will continue and may escalate over time without intervention.

E. WHY VICTIMS STAY IN ABUSIVE RELATIONSHIPS

A frequently asked question regarding victims in abusive relationships is "why don't they just leave?" While it seems a simple enough way to end the abuse, the reality is that leaving a violent/abusive relationship is anything but simple.

Leaving an abusive relationship does not guarantee an end to the abuse, rather, the abuse often escalates at the time of separation. The majority of domestic violence murder-suicides occur after the victim has tried to leave the relationship. The fact that many victims do leave or seek help is truly remarkable in light of the many barriers they face. Some of these include:

- lack of awareness of services
- fear of retaliation by the batterer
- lack of financial resources
- fear of losing custody of the children

- fear of not being believed
- religious, family and societal pressures
- shame
- denial of seriousness of abuse
- belief that the batterer will change
- lack of support network
- cultural and ethnic/racial barriers
- low self-esteem

Despite the many obstacles faced by victims, people continue to ask "why don't they just leave?" It is time for us to change the dialogue. Instead of placing the burden on the victim to get out of the abusive relationship, it is time that we shift the focus to the person responsible - the abusive partner. Instead of asking why the victims will not leave, it is time that we ask instead why do people abuse and why is it allowed to continue?

Impact Of Cultural Issues On Victims of Domestic Violence

Cultural differences can add further barriers to victims attempting to end abusive relationships. In addition to dealing with all the obstacles listed above, victims from diverse cultures must often work with programs and services that are unfamiliar with their language or customs and may seem unresponsive to their needs. Courts, social service agencies and advocacy programs often lack full-time interpreters to assist non-English speaking victims in filing complaints or accessing services. Shelters may not serve familiar foods or may have different beliefs regarding child rearing and discipline. Victims who lack experience with the criminal justice system or who fear law enforcement may tolerate the abuse rather than call police. And, undocumented immigrant victims may be afraid to involve law enforcement out of fear that contact with the criminal justice system could result in deportation for the victim and/or their family.

F. EFFECTS ON CHILDREN

Children of all ages can be deeply affected by domestic violence. While many victims attempt to and believe they can hide the violence from their children, advocates and law enforcement officers who come in contact with these children now know better. Although estimates vary, it is believed that approximately 85% of children in abusive households are aware of the violence. The effects can begin startlingly early. Infants exposed to violence may not develop the appropriate attachments to their caretakers

who are crucial to their development, and may suffer from "failure to thrive." Preschool children in violent homes may regress developmentally and suffer sleep disturbances,

including nightmares. School age children who witness violence exhibit a range of problem behaviors including depression, anxiety, violence, toward peers, and difficulty

with authority. In some cases the anxiety level can be so high children are afraid to attend school for fear of what will happen to the abused parent when they are not home (Family Violence Prevention Fund, 2000). Adolescents exposed to domestic violence are at increased risk for repeating abusive behavior patterns in their dating relationships. They are also at increased risk for alcohol and drug abuse, criminal behavior and eventual entry into the criminal justice system. A study funded by the National Institute of Justice found that early childhood abuse and neglect place victims at an increased risk for delinquency, adult criminality and violent criminal behavior. Being abused or neglected as a child increases the risk of arrest as a juvenile by 53 percent, as an adult by 38 percent and for a violent crime by 38 percent (Wilson, 1992).

In *The Children of Battered Women*, Jaffe (1990 et al.) offers the following list of symptoms:

- eating, sleeping disorders;
- mood related disorders such as depression, emotional neediness;
- overcompliance, clinginess, withdrawal;
- aggressive acting out; destructive rages;
- detachment, avoidance, a fantasy family;
- somatic complaints;
- finger biting, restlessness, shaking, stuttering;
- school problems and
- suicidal ideation.

In addition to the effects of exposure to DV, children who live with a batterer are also at risk of serious injury. Children can be the focus of the batterer's violence as a means of controlling the victim (threats to hurt children if the victim attempts to leave); children can be in the wrong place when the abuse begins (standing beside a victim when a chair is thrown); or older children may try to intervene (desperate to make the abuse stop, they get between the victim and the abuser).

While not all children will suffer physical injury or long-term emotional effects from exposure to domestic violence, recent studies of individuals in the criminal justice

system identified child abuse, sexual assault and domestic violence as common experiences of many adult male and female prisoners.

Providing support and referral to the victim of domestic violence is the first step in the process of ending the cycle of abuse for the victim and their children. Many types of community-based programs offer support and assistance through shelter services, treatment centers and advocacy programs

G. SAFETY ASSESSMENT AND PLANNING

Everyone who works with victims of domestic violence in any capacity should be aware of the basic elements of safety assessment and planning and the HCP is no exception. Domestic violence advocates recognize three basic steps when assessing the risks facing a victim and planning for her/his safety:

1. Understand how the abused person feels about their present situation.

The first step is often the most difficult one for those of us in health care because it requires us to step back and allow the victim to take the lead. Yet this step is absolutely crucial if we are going to provide effective intervention in domestic violence cases. An effective safety plan must be based upon the priorities, needs and options that the victim has identified as most important to her or him. Understanding how a victim feels about their situation can help us develop workable alternatives that fit the current circumstances. A first step is to assess whether the victim is afraid of their partner. Are they afraid to go home? Is the abusive partner currently in the vicinity? Is the victim planning to leave the situation, even on a temporary basis, or are they planning to return to the home?

2. Assess the immediate situation.

A second step is to assess the immediate situation based upon the victim's intentions. If she/he does not feel safe, are there friends or family to call, a safe place to go? Conducting a risk assessment can help the victim identify the level of risk they may face. Risk Assessments look at various factors such as:

- Does the abuser have access to a weapon?
- Have there been threats of homicide or suicide?
- Is the violence escalating?
- Is there substance abuse?

- Has there been a recent separation/filing for divorce?
- Are there court orders that limit access to children?
- Animal abuse?

Victims planning to leave the relationship have a number of options. They may call for shelter services, file a civil or criminal action or stay temporarily with friends or family. It is important to remember that except in those circumstances described in Section III, Legal Issues, it is a breach of confidentiality to call the police without the victim's consent.

HCPs can assist victims who are returning to their partners by exploring the emergency resources available to them. Does the victim have someone she/he can call if in need of help? Are there family members or friends to call or neighbors to alert? Can children be taught to call 911 if they become frightened by abusive behavior? It can be useful to discuss with the victim what they think will happen when they return home. How will their partner react? Are they able to anticipate violent episodes and take precautions?

3. Discuss the community and legal resources.

The third step in safety planning is to know the community resources and legal options available for victims of domestic violence and their families. The domestic violence hotline numbers are perhaps the single most important resource, but there are a multitude of services available throughout Delaware. Many of these are listed in Appendix B. In addition, it is helpful if the HCP is somewhat familiar with the legal recourses for those who have been victimized by an intimate partner. As described in Section III of this manual, there are both civil and criminal remedies that may be helpful to many victims of domestic violence.

SECTION III: DELAWARE LAW

A. DEFINITION OF DOMESTIC VIOLENCE

There is no one definition of domestic violence that applies to all incidents of abuse. Instead, different agencies and organizations have developed different working definitions. Relevant legislation defines domestic violence differently as well.

Generally however, domestic violence is defined as a pattern of controlling and assaultive behavior that occurs within the context of adult intimate relationships. It includes any injury or threat of injury between members of a family or intimate relationship, including husband and wife, boyfriend and girlfriend, same-sex couples, and parent and child, and could involve physical, sexual and/or emotional abuse.

B. LEGAL OPTIONS FOR VICTIMS

The provider who is aware of the legal options available in Delaware will be better able to facilitate access to these resources. Providers have two legal options to **suggest** to their patients:

1. Criminal Action

Report the incident to the police: Many acts of domestic violence constitute a crime under Delaware law. These acts may include but are not limited to threats to harm, harassment, and physical or sexual assault. Unless reporting is required due to an injury or circumstance as described under section C below, reporting to the police is a breach of confidentiality without the victim's consent. While a few states have mandatory reporting for suspected DV, Delaware does not provide for mandatory reporting except as noted herein.

2. Civil Action

Protection From Abuse orders are civil orders issued by the Family Court of Delaware. A Protection From Abuse action allows a victim of domestic violence to obtain a court order against their abusive partner. This remedy does not require police intervention but rather is an action between the parties involved in the relationship. Persons who can file for a Protection From Abuse order must

either be married, formerly married, living together at the time of the abusive incident or have a child in common. A PFA order can also be granted on behalf of minor children and disabled adults. Currently, same-sex partners and dating couples are not protected by any civil process under Delaware law. The Protection From Abuse order provides protection of the *petitioner*, who files the PFA, from the *respondent*, who is named in the PFA. The judge may order any or all of the following to be included within the protection from abuse order:

1. Prohibit contact of the respondent with the applicant
2. Temporarily assign use of property including house, vehicles, and checkbooks
3. Grant custody of children
4. Relinquish any firearms
5. Counseling or treatment

The protection from abuse order is granted for a specified time, up to one year. Another hearing may extend a PFA for up to an additional 6 months. A PFA issued in any county of the State of Delaware is enforceable throughout the country, and any person violating the PFA can be arrested without a warrant. The judge or justice of the peace will determine the amount of bail, if any. Though the Protection From Abuse order is not a guarantee of safety (there is no such thing), it is an important remedy for victims of domestic violence as they plan for their safety and that of their children.

There is a wide range of services available to all victims of domestic violence throughout the state of Delaware. These services include court advocacy and shelter services, legal assistance, community-based programs and more. Many victims will want to enlist the help of the Justice System, but others may choose not to for a variety of reasons ranging from shame to fear. It is important that victims understand there are numerous options available to assist them.

C. REPORTING ISSUES FOR PROVIDERS

Mandatory reporting: Delaware law requires any physician or health care practitioner to report the following (this is not a comprehensive list- it addresses injuries a provider may encounter):

- Any non-accidental poisoning (report to the police)
- Any stab wound (report to the police)
- Any bullet wound, gunshot wound, powder burn (report to the police)
- Suspected child abuse (report to Division of Division of Family Services)
- Suspected elder abuse (report to Adult Protective Services)
- Any 2nd and/or 3rd degree burn over 5% Total Body Surface Area, or significant respiratory tract burn (report to the Fire Marshall)

Injuries received by members of the Armed Forces while on duty are excluded. Failure to report the above injuries may result in a fine of no less than twenty-five dollars.

Reporting in accordance with this law shall be immune from award of damages. If the injury does not fulfill these above-stated conditions, then reporting domestic violence in the State of Delaware (and most states) requires the consent of the patient who sustained the injury or injuries. Reporting without consent, unless required by law as above, constitutes breech of patient confidentiality.

D. INSURANCE COVERAGE

It is illegal to refuse health insurance coverage for a patient because of injuries from, or history of, domestic violence. It is also illegal to refuse to cover any injury or problem because it is due to domestic violence. Any violations of this law should be reported to the Insurance Commissioner. In Dover/Kent County, call 302-739-4251 and ask for the Consumer Service Department. In New Castle and Sussex Counties, call the Consumer Services Department directly at 1-800-282-8611.

E. CLINICAL ILLUSTRATIONS:

These case illustrations provide examples of how health care providers should handle suspected domestic violence cases.

Case 1

A patient presents at a physician's office seeking treatment for a laceration to the thigh. The account offered by the patient is that the laceration was self-inflicted when they accidentally cut themselves while sharpening a lawnmower blade in their lap. The wound is large and jagged, but exhibits gunpowder stippling and does not appear to be a wound caused by a knife or lawnmower blade. When confronted with the powder burns, the patient states they are from ashes that fell off a cigarette and denies there being a gunshot injury. Despite the patient's denial, the physician contacts law enforcement authorities and reports that they are treating a possible gunshot wound.

Case 2

A very worried and anxious parent brings their four-year-old child to your office concerned about complaints the child is making. The child tells you that her shoulder hurts and cannot be any more specific. Upon examination, you find considerable bruising in the scapula area of the right shoulder. You find additional bruises and tender areas on the patient's back, buttocks and thighs. The parent indicates that the child falls frequently and plays with children who are sometimes rough. You interview the four-year-old and she indicates that at times the other parent spanks her. Radiographs show the scapula to be intact, but there is evidence of healed rib fractures. Given the extent of the injuries, the provider contacts the Division of Family Services and reports child abuse.

Case 3

A patient presents at your office with two black eyes and a contusion across the bridge of the nose. The patient explains that they opened the car door quickly and struck their nose causing the injuries. You notice bruising on the forearms and upper arms and fresh scrapes on the neck. Upon inquiring, the patient reports rough sex and occasional pushing and shoving matches with their spouse. The patient does not acknowledge that there is any domestic violence and despite your inquiries, does not wish to report the incident to law enforcement. You explain to the patient that you are very concerned for their safety, explain that there are people available to speak to confidentially about their situation, and then provide them with information about domestic violence services, including counseling, PFA, safety planning and shelters. You arrange for a follow up appointment and make a note to ask again about violence in the home.

SECTION IV:
HEALTH CARE PROVIDER'S (HCP'S) RESPONSE

A. INTRODUCTION

The epidemic of domestic violence that has gripped this country extends from the inner cities to the rural country, from the innocence of youth to the frailty of old age, from the very rich to the very poor, and from the front porch to the back bedroom. DV knows no boundaries with respect to race, color, gender or sexual preference. It is impossible to separate ourselves from violence entirely, for we are all touched. As health care providers (HCPs), we become involved at many levels. We care for the physical injuries resulting from the violence; we support the patient in their time of crisis; we encourage non-violent resolution to conflicts; and we refer patients to the appropriate community resources. This section provides an in-depth look at how a HCP effectively screens for DV and cares for victims.

B. BARRIERS TO DISCOVERY

For the Heath Care Provider, a major challenge is learning to recognize the problem of domestic violence for what it is. The patient strives to receive care for a presenting health problem, and hoping to keep the secret of their abuse to themselves, may never acknowledge the connection between the two. This is not a situation unique to DV. Consider the patient with chest pain and cocaine use, or the bulimic patient with periodontal disease. These patients often do not announce the underlying problem to their provider, and frequently conceal it. Additionally, HCPs do not recognize the underlying problem, or may simply choose not to probe further. Listed below are some common reasons why both providers and patients may not discuss DV.

For the provider, barriers include:

- Fear of opening "Pandora's box"
- Fear of offending the patient
- Time constraints
- Don't know what to do if abuse is confirmed
- Feel attempts are futile
- "Not in my practice" mentality
- Feel the victim caused the abuse
- Lack of awareness of DV and its signs and symptoms

"Pandora's box" is the potential for endless problems that will need to be addressed once the disclosure begins. It seems so much easier to prescribe a medication or refer to a specialist without even asking about DV. But the

problems don't go away. DV patients are likely to have more primary care office visits, mental health visits, emergency room visits and out-of-plan visits. When the real problem is not addressed, the symptoms are perpetuated. As providers we can become annoyed by the patient who just keeps coming back with one problem after another that we just can't seem to fix. Perhaps addressing the real problem from the start would be more effective.

Many providers fear they will offend their patient, thinking this is a private or personal issue. But so is intercourse and substance abuse, and as we have recognized the medical consequences of those personal issues, we have learned to ask about them. When asked in a caring, nonjudgmental fashion by a trusted professional in a safe setting, almost all patients react in a positive manner. Many are touched by the sensitivity of their provider, even if they are not in an abusive relationship.

Time constraints are real issues in virtually everyone's practice. Effective screening for DV takes far less time and effort than one might think. It certainly takes less time than not asking about it, in the long run. The educated provider can screen for DV in a few seconds, and can make appropriate referrals in most cases in just a few minutes.

Many clinicians choose not to ask about DV because they wouldn't know what to do if they actually found someone who was abused. Hopefully this manual will help to alleviate this concern. As with any clinical problem, we must develop appropriate assessment and intervention skills. Various tools are available, and many are included in this manual, to assist the provider in their assessment, documentation and referral of DV patients.

Despite our most compassionate efforts, DV patients often return to their abusers. The victim may leave and then return to his or her partner a number of times. For the provider who sees the patient in follow-up, this pattern of behavior may be frustrating or discouraging. But it also is typical, and not unexpected. Our continued support of the patient can be a source of strength and can enhance the patient's ability to plan for their safety and for the safety of their children.

Many clinicians do not ask about DV because they have never encountered it and thus assume it doesn't exist in their practice. Just as it would be difficult to

diagnose thalassemia minor without a CBC, it is difficult to diagnose DV without asking about it. Patients with more education or economic resources are not

immune to abuse. They may have more sophisticated alibis for their injuries, and are less likely to be discovered. Regardless of socioeconomic class, all patients should be screened for abuse.

Many providers may ask the patient what she/he might have done to cause the violence. The HCP doesn't realize that asking such a question may reinforce the patient's misplaced sense of responsibility (or blame) for the abuse. Such questions are simply inappropriate for any victim of abuse. Even if the victim is anxious, agitated, or perhaps intoxicated, they do not deserve to be beaten. Physical abuse is against the law in every state. Though some victims of DV may turn to alcohol or drugs as an escape from their psychological and physical torture, substance abuse does not cause the violent behavior.

Still, the biggest reason providers don't ask about DV is a lack of awareness. Rodriguez et al. (1999) reports that 31-54% of female patients seeking emergency services, 21% to 66% of those seeking general medical care, and up to 20% of those seeking prenatal care report experiencing intimate partner abuse. It is more than prevalent; it is *epidemic.* But awareness goes beyond understanding the prevalence of DV. It requires an understanding of the dynamics of domestic violence, the various patterns of physical injuries, the common associations with non-traumatic physical symptoms, and the frequency of psychological problems that can occur with DV victims.

For the patient, there are also many barriers to reporting:

- Children
- Cultural or religious values
- Fear of violence/retaliation if the abuser finds out about disclosure
- Isolation
- Concern partner will be arrested
- Hope that partner will change
- Lack of knowledge of available resources
- Healthcare provider doesn't ask

Many people sustain relationships "for the sake of the children." The perpetrator of the violence may threaten to leave with the children, or kill the children, if the victim reveals the violence to anyone, or tries to leave. Children

may not want parents to separate and may blame the victim if she/he leaves the abusive partner.

Victims of abuse sometimes remain in relationships because of cultural or religious beliefs that encourage them to stay with their partner. Cultural and language barriers may also make it difficult for victims to seek assistance. For example, immigrant victims can face complex legal issues when disclosing domestic violence and illegal immigrants are especially likely to fear the consequences of reporting to law enforcement.

The victim may fear retaliation on the part of the abuser if the violence is reported. Disclosure can lead to increased violence, in effect "penalizing" the victim. These fears can be addressed with reassurance that the conversation is confidential, providing the abuse does not include stabbing, gunshot wounds, poisoning, or child abuse (see Section III: Legal Issues).

The victim of domestic violence may have become isolated from family and friends as a result of the power and control tactics used by their partner. These tactics can result in financial (sole provider of income, controls checking/savings accounts), geographical (moves away from family and friends), and psychological ("nobody would want you") isolation. With nobody else to turn to, the victim is compelled to tolerate the violence.

The victim of abuse may fear their partner will be arrested if they acknowledge the abuse. Victims sometimes fear that an arrest will result in jail time and job loss for the abusive partner. An arrest can also heighten the risk of further abuse when the partner is released. Some family members may blame the victim for the abuser being arrested.

Victims of abuse may continue to love their partner and continue to hope for a relationship without violence. They focus on the good moments of the relationship, and may minimize the effects of the abusive behavior. Victims and abusive partners may not view the violent behavior as abnormal in the context of their own experience. This may relate to their own observations as children, or their cultural/religious beliefs. Unfortunately, the violence can escalate over time.

Victims of DV may not be aware of the community resources available to assist them. Victims often have little knowledge of the legal resources and social services available to them in the community.

Patients often do not talk about DV because the health care provider doesn't ask them. When asked in a supportive, safe environment, most patients will answer truthfully. They truly may not connect their physical symptoms to the abuse, just as a patient on high doses of over-the-counter ibuprofen may not realize that it can cause renal insufficiency. They often will not bring up the subject unless the provider asks.

C. APPROACH FOR THE HEALTH CARE PROVIDER

The informed provider will find patients who are victims of DV really want help, and are open to discussing their abuse with a compassionate, understanding professional. The following list is helpful as an overall approach toward victims of DV:

1. Set the Tone

- Interview the patient alone. Asking about DV in front of the perpetrator is endangering the victim.
- Encourage, but never force the patient to disclose or leave the abusive relationship.
- Show compassion and understanding, even in the event the victim declines to leave the relationship or seek other resources.
- Be supportive- "You don't deserve to be hit. It's against the law."
- Send a clear message that violence is unacceptable.
- Ensure the victims safety at all times.

2. Things to Avoid

- Avoid assigning any blame to the victim. Ask questions in a nonjudgmental manner.
- Avoid the terms "battered," "abused," or "victim of DV," as the victims often do not see themselves in that way.
- Avoid breach of patient-provider confidentiality, within the limits of the law.

3. Checklist

- Address the presenting complaint. Complete the history and physical, including screening questions about DV.
- Ask simple and direct questions- "Did someone hit you? Who?"

- Do safety assessment for acute lethality risk.
- Inform the patient of available options, initiate necessary treatment and make appropriate referrals.
- Document the visit, recommendations and response.

D. UNIVERSAL SCREENING

Recently, several professional societies, including AAFP, ACOG, ACEP, ACP and AAP, have promoted universal screening for DV. They recognize that we just can't tell from the history and physical and demographics, and that the issue is too important to overlook. Universal screening involves asking each adult about partner abuse. This is advocated in primary care settings, Emergency Departments, clinics, home health, nursing homes (for elder abuse), injury evaluations, mental health evaluations and for all inpatients. This, combined with education on effective screening techniques and a heightened awareness of DV, will increase our success rates, and decrease the suffering of our patients.

A minimalist approach would be to screen only individuals with the above criteria. However, these criteria are inadequate as a screening tool for a lethal situation. It would be like talking about safe sex only with homosexual males. They have a higher prevalence of HIV, and need to be counseled, but most of our patients also need to be counseled. We would be addressing a very high risk population, but ignoring the majority of patients at risk.

Many hospitals and offices employ a selective approach to screening for DV. That is to say, when a patient reports they have been assaulted, it is acknowledged, and the patient is appropriately referred. Rodriguez et al reported (1999) that family physicians in California screened for DV in 79% of patients presenting for injuries, but only in 9-11% of patients presenting for non-traumatic reasons. Selectively screening for DV only in trauma patients misses most victims.

Most people involved in an abusive relationship present with nontraumatic problems. Abbott et al (1995) showed that 77% of battered partners presented to an Emergency Department with non-traumatic complaints. These can run the gamut of medical illnesses. A recent study (Muelleman et al., 1998) listed the most common non-battering diagnoses in patients found to be victims of DV, using routine screening techniques. The top six diagnoses comprised only 19.8% of the patients who were abused. So even screening all injured patients, plus the most common non-traumatic presentations, would be inadequate.

Failing to detect DV has consequences. Victims of DV are three times more likely to be re-victimized within six months than victims of any other kind of violence. Over a 57-month period, 30% of patients treated for DV related injuries returned with another injury caused by their partner (Muelleman et al., 1998). Also, 19% of the patients without DV related injuries returned within the same time period with injuries caused by their partner. How many of these can be prevented?

The conclusions of many experts in this field are:

- DV is prevalent in virtually all sectors of society.
- The physical and psychological consequences are devastating.
- Self-reporting has inadequate sensitivity.
- Screening based on suspicion is inadequate.
- Victims are open to direct questions about violence, in the proper setting.

E. SYMPTOMS AND SIGNS OF DV

The victim of DV may present with a variety of symptoms and physical findings. Sometimes victims do not realize their symptoms are linked to their abuse, and frequently do not offer the true etiology of their physical injuries. The provider must, therefore, be looking for these three types of indicators, and screen routinely:

1. Physical Symptoms

   - Chronic pain, psychogenic pain, or exaggerated pain response
     - Headaches
     - Atypical chest pain
     - Abdominal pain/gastrointestinal problems
   - Symptoms of depression
     - Sleep and appetite disturbances
     - Fatigue
     - Difficulty with concentrating

- Genito-urinary problems
  - STDs
  - Frequent U.T.I.s
  - Dyspareunia
  - Pelvic pain
  - Miscarriage/vaginal bleeding
  - Premature labor
- Vague neurologic symptoms
  - Dizziness
  - Paresthesias

2. Physical Injuries

An abusive injury can take any form. The following should arouse more than the usual suspicion:

- Injuries to the head, neck, chest, breasts, abdomen, and genitals
- Injuries during pregnancy
- Placental abruption
- Multiple sites of injury
- Injuries in various stages of healing
- Sexual assault
- Any bite mark
- Repeated or chronic injuries
- Injuries that are inconsistent with the history

3. Behavioral Indicators
   - Patient Behavior
     - Patient is evasive, frightened or anxious
     - Patient is reluctant to leave
     - Concern is out of proportion to the problem
     - Doctor shopping
     - Frequent visits, or frequent missed or cancelled visits
     - Suddenly leaving a provider's office or hospital
     - Explanation is inconsistent with normal physiology, or inconsistent with injuries
     - Patient is reluctant to answer questions in presence of partner
     - Prescription, alcohol, or other substance abuse problem
     - Suicidal ideations, suicide attempts, or overdoses
     - Noncompliance with medications

- Partner Behavior
  - Partner answers questions for patient
  - An overly attentive partner
  - Partner is reluctant to leave when asked to do so
  - Partner minimizes injuries
  - Partner demeans or attributes blame to the patient
  - Partner has a substance abuse problem
  - Appointments cancelled by a partner

F. SCREENING TECHNIQUES AND SAMPLE QUESTIONS

The attitude we use in screening for DV may contribute more to the success of this endeavor than the content of our questions. Showing sincere interest, asking questions in a non-intrusive, non-judgmental, open-minded way have always been hallmarks of successful interviewing. For DV screening, it is crucial because the victim 1) may have been treated in the past in a demeaning, unsympathetic way by the health care system, and 2) their "secret" is so personal and closely guarded that they may be reluctant to share it with anyone other than someone who conveys a feeling of sincerity and trust. For the individual caught in abuse of any kind, the initial and more focused screening questions may be the first ray of hope for them, a bridging with others that may end their isolation.

Before asking about abuse, create a safe and comfortable environment, allowing the patient to relax and talk freely. An exam room with a closed door provides the privacy and security that many victims require before they will acknowledge abuse. The waiting room and front desk are less likely to promote disclosure.

Avoid body language that conveys, "I'm in a hurry," "I don't care," or "I'm uncomfortable hearing this stuff." The HCP's tone of voice and eye contact are crucial. The patient must feel that they are being treated with respect and listened to in earnest … the way we should approach patients when dealing with any other condition.

The questions should be integrated into the flow of the history. This becomes easier and more natural as we learn the many ways that DV can affect an individual. Asking about any injuries or recent stressors provides a good segue for most visits. Asking about partner violence out of context, without properly framing the question, can lead to suspicion on the part of the patient. Examples of framing techniques include:

- "I don't know if this is a problem for you, but many of my patients have partners that hit them, threaten them, continually put them down, or try to control them. Is that a problem for you?"
- "Have you been under any stress lately? Are you having any problems with your partner? Do you ever argue or fight? Do the fights ever become physical? Are you ever afraid of your partner? Have you ever been hurt by your partner?"

The direct approach may also be useful, especially when the provider is suspicious:

- "Did someone hit you? Who was it? Was it your partner?"
- "Do you feel controlled by your partner? Have they ever tried to restrict your freedom or keep you from doing things you felt were important?"

How we ask the question has a large impact on the validity of the response. A study (Feldhaus et al., 1997) showed the following three questions to be sensitive and specific for routine screening for DV:

- "Has your partner hit, punched or kicked you, or threatened to do so?"
- "Have you ever felt afraid of your partner?"
- "Has your partner ever hurt you?"

G. SUPPORT

Support begins before we even ask about DV. It's in our approach, tone, and other nonverbal cues. The patient and provider build a rapport, and we build on that when we encounter someone who is being abused. For a patient who acknowledges DV, immediate support is important to begin the process of restoring self-esteem. Here are some examples of provider responses:

- "Nobody deserves to be abused. There are people who can help you."
- "You are not alone. I'm glad you feel comfortable sharing this with me."
- "It's not your fault."

Further support comes with the steps that follow, and sense for the patient that maybe there is hope, that maybe I don't deserve this. It will take time, patience and encouragement to weave through the many hurdles of surviving a

violent relationship. A supportive provider can be a vital participant in that process.

H. SAFETY

Safety issues include the well being of the patient, children or other loved ones, and pets. These issues can be divided into 1) immediate safety issues, 2) safety assessment for acute lethality risk, and 3) safety planning. The first two can and should be done by the provider, in a very short period of time. Safety planning is more involved, and can be done by a provider or by a DV counselor.

1. Immediate concerns for safety may prompt a call to police or security, or simply locking the door. Consider the following questions:

   - "Is your partner here now? Does he/she have a gun or other weapon?"
   - "Do you feel safe leaving with your partner, or would you like us to find another place for you to stay, in safety?"
   - "Do you want to call the police? Do you want to report this?
   - "Do you need someone to pick up the children?"
   - "Do you have to be home by a certain time?"

2. Safety assessment for acute lethality risk can be done with a simple checklist (see Appendix C: Safety Screening Tool). Patients with one or more positives are at increased risk of DV-related death. The decision to leave, however, remains with the patient, as leaving often increases the immediate risk. Also, the absence of any of these factors does not guarantee the patient will not be killed or severely injured. Nonetheless, consider the following questions:

   - "Is the violence escalating?"
   - "Has your partner hurt or abused the children?"
   - "Has your partner injured, killed or abused any animals?"
   - "Is there a gun in the house?"
   - "Has your partner threatened to kill you, a family member or himself/herself?"
   - "Has your partner threatened to take the children away?"
   - "Are you afraid your partner is going to kill you?"
   - "Is your partner stalking you?"

3. Safety planning involves preparing financially, organizing an escape plan, making lists of important phone numbers, and discussing options. Pamphlets

are available to help organize the safety plan, in multiple languages (see Appendix D: Safety Plan).

I. REPORTING AND REFERRAL

The victim of DV in Delaware has many options. The HCP may advise on the availability of the following types of resources (see Appendix B: Resources):

- 24-Hour Hotlines
- Shelters for female victims of DV and their children.
- Counseling programs for victims and perpetrators.
- Reporting to police.
- Protection from abuse orders (PFA).
- Assistance with transportation.
- Legal assistance.

The hotline should be the main referral option for HCPs. Advocates on the hotline can interview the patient to determine their needs, and advise them of programs and services available. Although shelters specifically for male victims of DV are not currently available in Delaware, the Hotlines can help with referral to other shelters accepting males, and arrange for other support services as needed.

The duty to report certain acts of violence occurring in the State of Delaware applies to DV as well. If any of the following occur, the police must be informed:

- Stab wound (deeper than it is wide is the usual definition).
- Gunshot wound.
- Nonaccidental poisoning.
- Burn over 5% Total Body Surface Area (total of 2nd and 3rd degree).

The duty to report applies even if the victim does not wish to do so. The provider faces a fine of no less than twenty-five dollars. However, if the provider reports child abuse, they are not to report the violence committed against the adult partner without the victim's explicit permission to do so. Reporting to the police without the victim's permission, with the above exceptions, is breach of confidentiality. The AMA and several specialty societies, have promoted recognition and referral of DV victims, instead of trying to mandate universal reporting. A few states, however, do have mandatory reporting for DV. (See Section III: Legal Issues.)

J. DOCUMENTATION

The medical record should be completed with two principles in mind:

- Describe the details of the history and physical exam precisely and accurately, including the name of the perpetrator of the violence, a description of the assault or controlling behavior, and an objective description of the injuries or findings.

- Avoid any subjective interpretation of events or data. Use the patient's own words whenever possible.

For example, "35 yo WF states she was punched in the face by her ex-husband, Bill, with a closed fist two days ago. She further reports he attempted to strangle her with a telephone cord later that night. She complains of pain in the left eye and face, and double vision with upward gaze. Visual acuity is 20/20 O.S. and 20/20 O.D. Exam reveals purple bruising to the left periorbital region with moderate edema, with subconjunctival hemorrhage and limitation of upward gaze of the left eye. There are petechiae of the right eye and a ligature mark around the neck measuring 3 mm wide and 15 cm long."

Body maps and photographs are helpful for acute injuries. Written consent for taking the photographs should be obtained. A body map has been incorporated into the Safety Assessment Tool in Appendix C, with room for documentation of the history, physical, consent for photographs, and referrals. Any photographs taken should be labeled with the patient's name, medical record number and date, and secured with the rest of the chart.

K. CLOSURE

Caring for victims of DV is both frustrating and demanding. Victims often leave and return to their abusers several times before leaving for good. The provider is engulfed in the helplessness of the situation, but must maintain a supportive approach to the patient. The result is a trusting relationship with a compassionate provider, who provides nonjudgmental treatment, and above all, cares. That's what we do best.

SECTION V: PREVENTION

A. Bridge to the Future

B. Primary Prevention- Before the Abuse Occurs
   1. Setting an Example of Intolerance of Violence
   2. Education
   3. Innovative Parent-Child Programs
   4. Leadership in Organized Medicine

C. Secondary Prevention (For the Known Victim)
   1. Safety Screening and Assessment
   2. Holding the Perpetrator Accountable
   3. Support and Advocacy

A. BRIDGE TO THE FUTURE

Prevention is the keystone in our response to this epidemic of domestic violence (DV). As important as our efforts are in finding and helping current victims, it is equally important that we work to eliminate the social and cultural conditions that contribute to DV. We must undertake the thoughtful discourse, planning and action so that the specter of DV appears less often and with less intensity in the days, months, and years ahead. Consequently, it is helpful to view prevention as a bridge from the present to the future:

P R E V E N T I O N

Present	**Future**
Cultural values reflect a high level of tolerance for violence. Relationship conflict characterized by abusive and controlling behaviors.	Social intolerance of interpersonal violence and violence in general. Cultural values and laws allow all people to live free from verbal, physical or sexual assault.

Present	**Future**
Victims of relationship violence live with the effects of physical and psychological abuse.	Interpersonal relationships defined by mutual respect and responsibility.

The health care industry can work to prevent DV at community, state, and national levels. This work can take place within organizations, including any group of people delivering some aspect of health care; and at the individual level, where HCP meets patient. However, preventive efforts can be successful in Delaware only if they reach (inform) and touch (persuade) the minds and hearts of each Delawarean. That is, we must first tell the citizens of our state about the prevalence and seriousness of DV ... and then persuade them why it is in everyone's best interest to engage in ongoing prevention and education efforts. In this regard, prevention may be the only hope for breaking the cycle of violence.

B. PRIMARY PREVENTION (WHERE ABUSE HAS NOT YET OCCURRED)

1. Setting an Example of Intolerance of Violence

There is in this society and within the health care profession a great deal of consciousness-raising that can be done. Much has been accomplished by the efforts of many victims and pioneers working to bring the issue of DV into the public eye. Every health care provider can potentially play a supporting (and in some cases**,** leading) role in this effort. Patients look to us with respect, trust and hope. Our mission, as with all patients, is to provide cure sometimes but support and comfort always. They look to us to be their advocates, in the truest sense of the word, by "looking out for them." What we say and how we respond to our patients can be extremely important.

As the medical community of Delaware, as a member of a health care organization within Delaware, or as an individual interacting one-on-one with patients, each of us has several opportunities to prevent abuse. And, we can do so at each of these several levels. At the level of interpersonal interaction, we can set an example of intolerance with regard to violence. Just as it is important for parents to verbalize to children their thoughts about sex, drugs, morals, etc., so also is it important that HCPs speak and act in ways that unmistakably convey to patients a disdain for controlling or violent interpersonal behavior and a willingness to help prevent abuse in any form.

2. Education

At the level of state and community-administered programs, there are several mechanisms to increase public awareness of DV and the need for change. As detailed elsewhere in this Resource Manual (see Legal Issues), Delaware law provides both civil and criminal protections to victims of DV. The posting of this law in public places - particularly all health care facilities, including private physician offices - would send a clear message about the legal rights of those who are abused. For victims, it offers hope and conveys a message that legal and health care entities both will provide support and assistance. Perpetrators who read such postings may realize that the heat is on, that they are under scrutiny and that they will be held responsible for their behavior.

HCP support of existing and future violence prevention programs will aid in the dissemination of information to the public. Earlier in the 1990s, the U.S. Surgeon General Antonio Novella, M.D. called on physicians to form coalitions with parents, educators, social service workers, other health care workers and community leaders to develop programs that tackle issues ranging from parenting education, to caretaker assistance, to conflict resolution. Programs that provide information on DV and related

problems can help community members to develop the skills necessary to discern patterns of controlling behavior and to confront them before they lead to abuse. The many agencies in Delaware and throughout the U.S. (see Appendix B) that provide direct services to victims and their families need resources (financial, volunteer time) in order to expand their outreach into the community. Posting the names, addresses and phone numbers of these organizations in all health care facilities (hospitals, insurance companies, and the offices of physicians, dentists, physical therapists, chiropractors and dieticians) and in all state, county and local health-related agencies can provide state-wide impetus for prevention efforts related to DV.

Prevention efforts would see immediate and long-range results if training and other curricula regarding DV were made available to all physicians and other health care workers. HCPs have the opportunity but lack the awareness and training to actively direct preventive programs and treatment of DV. This dearth of knowledge and skill can change through CME seminars, hospital meetings and lectures, reading and scrutiny of medical protocols. Discussion of issues of clinical and interpersonal respect may, by "bringing their own house in order," allow some HCPs to shed the condescending attitude which has often hampered optimal patient care in the past. The education process of HCPs may be more complex than anticipated, especially if the behavioral changes expected of a HCP may conflict with his/her personal needs and cultural values. For HCPs to play an important role in long-term prevention, their learning must involve all three: 1) knowledge, 2) attitudes, and 3) skill.

Thus forewarned, training programs need to be especially creative. Required inclusion of DV issues in medical school curricula and residency programs at Delaware hospitals would enable the next phase of new physicians to bring a still greater awareness of DV with them to the patient care setting. Similarly, "in-service" programs for hospital personnel and all medical office personnel will assist those individuals in understanding and addressing DV among patients and within their own household relationships. Training of the hospital and office staff must include a) interviewing techniques, b) dynamics of DV, c) safety assessment, and d) linking to local resources. It is key, however, to acknowledge that for HCPs to incorporate and maintain an effective response to DV, they must have the support of the institution in which they practice. Thus, the leaders of hospitals, physician groups, physical therapy groups, etc., all must be given the chance to learn, to discuss and hopefully embrace the need for system-wide support for HCP activities on behalf of DV.

3. Innovative Parent-Child Programs

Because DV is a public health problem passed from one generation to the next, more attention is being paid to the effects on children and the parent-child relationship than ever before. In addition to parenting classes for parents and conflict resolution workshops for children, we now have Visitation Centers where parents sharing custody can safely exchange children. There is much being done in Delaware in these areas, but there is more that can be done. Some of the recommended innovations include:

a. Nurse visits to new mothers: Dr. Richard Krugman, Director of the C. Henry Kempe Center for Child Abuse, noted that "the single most effective intervention to prevent child abuse would be the development and support of a system of voluntary universal neonatal visitation (1992)." While insurance company driven early hospital discharge for mothers and newborns has brought on such visitations, perhaps a system involving all newborns and at periodic intervals would help achieve this goal.

b. Parents and babies: Educational efforts by community organizations, hospitals and physician offices could teach parents about newborns, encourage them to read to children, and give men permission to nurture and bond with children in ways other than the societal stereotypes.

c. Discipline counseling for parents: Programs to offer parents alternatives to physical or corporal punishment may include various topics such as:

- Use of the Time Out mode of discipline
- Use of positive rewards, consistent rules enforcement
- Information on the development stages of childhood
- Review of educational pamphlets such as Twelve Alternatives to Whacking Your Kid (available from the National Committee for the Prevention of Child Abuse).

d. Parental control over television and other media: Programs to increase parental awareness regarding the effects of TV viewing (and related activities such as computer and video games) on the development and behavior of children.

e. Conflict education: Courses can help throughout the K-12 education of a child, and certainly should begin at the elementary level. They should involve parents at every level, from creation to implementation, because of

the very sensitive nature of the topic. Teachers would need even more intensive training.

f. Anti-violence programs for adolescents: Programs could provide information on interpersonal relationships, resolving conflict and dating relationships. Effective prevention programs can range from theater presentations to peer counseling.

Opportunities to assess the attitudes of children and adolescents as well as the chance to modify their beliefs and skills can occur in the HCP's office where a teenager gets to know someone over a period of time. This opportunity may also arise in mental health/counseling relationships, in interactions with religious leaders, and certainly within a teenager's own household. HCP's can encourage families to incorporate non-violence as part of their every day interactions. Using positive reinforcement as a motivator rather than fear of punishment or rejection will help teenagers cope better with frustration, depression and anger. Parents and health care providers have not served the adolescent population well in terms of role modeling and guidance. Extra DV preventive efforts would yield much for the time and resources spent, particularly as teenagers enter into the realm of dating relationships, marriage and parenthood.

4. Leadership in Organized Medicine

Hospitals and professional societies (of physicians, nurses, and allied health professionals) can serve as focal points for preventive efforts relating to DV. The partnership between HCPs and hospitals offers multiple opportunities to teach about and prevent DV. Hospital sponsored seminars, lectures, and joint-sponsored community outreach programs are the kinds of vehicles available. Auxiliary organizations of both the medical and dental society and the hospital could provide another enthusiastic resource base from which preventive programs in DV could begin.

Doctors can play a leadership role through organizational activities and in one-on-one patient interactions where they have the opportunity to demonstrate respectful, non-abusive behavior toward their patients and their staff. For example, demeaning behavior (words and/or actions) toward staff may need to be challenged when observed by colleagues. The defensive plea by some that (perceived) incompetence by support staff warrants belittling, condescending behavior from the physician is no longer acceptable.

The business schools of this country, where leadership style and effectiveness of organizations are studied in great detail, recognized long ago that leadership by fear may achieve very short-term success, but will almost certainly undermine the long-term strength and effectiveness of the organization. There are better ways to achieve successful (team) work in the office or O.R. or clinic without nearly destroying the morale and psyche of the workers in the process. While the verbal tirades of HCPs and their staff do not constitute DV, these outbursts reflect the kind of disrespectful, controlling attitude that supports DV. It is best eliminated if patients and staff are to believe the sincerity and intentions of HCPs to confront DV.

Hospitals and other JCAHO-approved institutions have a written mandate to devise in-house protocols. Most people do not know this, including most hospital employees, many physicians, and a few administrators. Periodically publishing/posting each organization's protocol in public hallways and in other areas accessible to employees would serve part of its purpose by again raising awareness of this issue. Since most individuals will pay attention to those they know well or trust, it behooves the office-based physician as well as other HCPs to have visible posters and verbal reminders about the issue of DV. Simply asking questions (see Appendix E) of each teenager, parent, and adult - both as a new patient and on subsequent routine or "checkup" exams - will serve a preventive benefit. It will reinforce attitudes of that HCP, and will also send two important messages: 1) the physician is concerned about his/her patients' emotional well-being; and 2) placed on equal footing with questions about cigarettes, chest pain, bowel function and menstrual pattern, the issue of controlling, emotionally damaging behavior becomes just as important as those "organic" concerns.

Since we are contending with prevailing societal attitudes, which condone or tolerate violent solutions to conflict, concerted efforts to modify those attitudes and behaviors will be needed for more than a few years. If preventive efforts enjoy early success and are then left to stagnate, this benefit will come undone. Therefore, all of the above preventive strategies and mechanisms must be reviewed and repeated. Educational efforts need to be repeated a) to remind those whose consciousness may have been raised on the first pass, and b) to bring new employees or persons with changing relationships and attitudes up to date. Skills and strategies learned must be practiced; otherwise, they will fade from disuse.

C. SECONDARY PREVENTION (For the Known Victim)

Secondary prevention relates to the efforts of advocates, HCPs, criminal justice personnel and others who work with victims and perpetrators of DV on a daily basis. Details of how we accomplish these secondary prevention interventions are found in Section II: Understanding DV, and Sections IV-B and IV-C relating to assessment and treatment. Secondary prevention has two central goals:

- To enhance the safety and autonomy of the victim/survivor.
- To hold the perpetrator accountable for the violence.

1. Safety Screening and Assessment

For the HCP, secondary prevention entails understanding the dynamics of abusive relationships, the safety issues involved, and the role of community resources in assisting victims of DV. For example, once DV is confirmed, a safety assessment can help evaluate the victim's immediate risk. The HCP should complete a safety assessment and provide the patient with the local DV Hotline number. DV advocates can then provide information regarding available legal options and safety planning. They can also help the victim determine whether shelter, counseling, case management or other services will be of benefit. Shelters provide a safe place for women victims and their children who are in immediate danger. Other community-based services offer support groups, assistance in filing for Protection From Abuse petitions, counseling for victims and their children, housing assistance and legal aid. It is helpful for the HCP to become familiar with the legal options and services that are currently available to DV victims and the elements of safety planning. In the event that a patient is reluctant to contact a DV program, the HCP may be able to offer information regarding legal rights and services. In all cases, the autonomy of the adult victim must be preserved and respected. Some victims will choose not to report their abuse to law enforcement and will not want to contact the DV Hotline. Except under those circumstances mandated by law (see Section III: Legal Issues), the HCP should abide by the patient's decision.

2. Holding the Perpetrator Accountable

Secondary prevention efforts must effectively hold the perpetrator accountable for the abusive or violent behavior. Victims of DV should never be held responsible for the behavior of their partner. Justifying violence or abuse because of the victim's actions only serves to reinforce and collude with the conduct of the perpetrator. The abusive partner may be held accountable in a variety of ways. A Protection From Abuse petition may be filed in Family Court or a call to the police may result in criminal action.

Batterer Treatment Programs offer a curriculum specifically designed to challenge the attitudes and beliefs of abusive partners. While these efforts are all important methods of holding a perpetrator accountable, the most important step we can all take is to reject the use of violence and abuse in relationships and to hold each offender responsible for their own behavior.

3. Support and Advocacy

Secondary prevention can only occur one person at a time. It is crucial that the HCP not dismiss or lose patience when a victim chooses to return to an abusive relationship. If we do, we certainly will lose the confidence and trust of the person we are trying to assist. Instead, we need to show, sincerely, that his/her decisions are respected; that we do not judge the person by whatever choice they make at that moment. By supporting the victim and clearly outlining the options and community resources, we adopt a patient-advocate role. This supportive role helps to insure that if the patient is ever in need, they will return to us again for help and support.

Vigilance is a useful attitude when we as HCPs act as advocates for patients who are abused. We need to screen routinely for DV and keep abreast of the services and legal options available to our patients. Vigilance is needed to insure that these preventive efforts - primary/secondary, - state-wide/community-wide, individual - do not fade from use and visibility. If they do, perpetrators and perpetrators-to-be will find it easier to revert to prior attitudes and behaviors, largely because they and their neighbors, through indifference or lack of fortitude, have given them tacit approval to do so. With continued vigilance, however, the educational initiatives, training programs and protocols are more likely to remain well funded and well used. Sustained effort is the best weapon for interrupting the cycle of interpersonal abuse.